MONTEFIORE

VOLUNTEER & STUDENT SERVICES
111 EAST 210 STREET, BRONX, NY 10467
718-920-4191

REQUIREMENTS

Original and Non-Laminated Documents Only

1. Bring State/Government Picture ID and Social Security Card, United States work authorization documents, United States Visa/Passport
2. File an application
3. Physical Examination (Performed by applicant's physician) within 1 year (form given by Volunteer Dept.)
4. IPPD skin TB test within 1 year (***QuantiFERON TB-Gold is accepted***). If positive make sure to attach the written interpretation of chest X-ray from doctor, also within 1 year (Performed by applicant's physician).
5. Influenza Vaccine is **mandatory** during flu season *(September – May, when prevalent).*
6. We do not cover any medical costs associated with volunteer requirements.
7. All Applicants are required to deliver the above in person during the listed hours of operation below.

Commitment: Minimum of 4 hours per day/3 days a week a total of 200 hours of volunteer service within 6 consecutive months or summer term. Must be medically and administratively cleared including but not limited to background screening and drug testing.

JUNIOR VOLUNTEERS - IN ADDITION TO THE ABOVE:

1. Must be 16 years of age and over
2. Parental consent
3. Guidance Counselor's Recommendation
4. Working papers
5. Birth Certificate
6. Hand written essay **Topic:** *Why would you like to volunteer in a healthcare facility?*
7. Donate a minimum of 100 hours of service during the academic year and/or a minimum of 100 hours of service in a two-month period during the summer months.

The application process takes an average of seven to nine business days during the academic year and ten to fifteen business days during the summer months.

General Information:

Hours of Operation to Submit Application & Medical Forms:

Monday – Thursday

8:30 a.m. – 11:00 a.m. 1:00 p.m. – 2:30 p.m.

Interviews: By appointments only

Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

VOLUNTEER HEALTH CLEARANCE FORM

No other medical form is accepted by Montefiore as a pre-condition to volunteer placement.

Name: _____ **DOB**: _____

Home Address: _____ **Home Phone #**: _____

_____ **Cell Phone #:** _____

Annual Physical Assessment ***(must within 1 year)*** Date: _____

☐ **Flu Vaccination** Date: _____ Lot#: _____ Exp. Date:_____

Mandatory Influenza Vaccine during Flu-Season (September - May, each year when prevalent)

☐ Varicella Titer Date: _____ ☐ Negative ☐ Positive/Immune
☐ Measles Titer Date: _____ ☐ Negative ☐ Positive/Immune
☐ Rubella Titer Date: _____ ☐ Negative ☐ Positive/Immune
☐ Mumps Titer Date: _____ ☐ Negative ☐ Positive/Immune
☐ Hepatitis HbsAB Titer Date: _____ ☐ Negative ☐ Positive/Immune
☐ Diphtheria – Tetanus (within 10 years) Date: _____

☐ Hepatitis HbsAG Titer Date: _____ ☐ Negative/Non-Reactive ☐ Positive/Reactive
☐ Hepatitis B Declination Form: ☐Signed ☐ Not Required (had Hep B vaccination)

Required Titers & Immunizations: Dates must be written for each Titer (no arrows, lines, etc.)

Select ***(must be within 1 year)*****:**

☐ **Current *IPPD/Mantoux Date Placed:** _____ **Date Read:** _____ ☐ Negative ☐ Positive

☐ ***QuantiFERON TB-Gold test*** **Date:** _____ ☐ Negative ☐ Positive

☐ ***Chest X-Ray*** **Date:** _____ ☐ Negative ☐ Positive

*** If positive, copy of negative x-ray *AND* official written report from physician w/in 1 year required Must be available to Montefiore upon request.**

This is to certify that, to the best of my knowledge, this individual does not pose a medical risk to himself/herself or to others.

_____ _____

Signature and Stamp of Practitioner/Facility Date

☐ **CLEARED** to volunteer ☐ **NOT CLEARED** to volunteer

I hereby authorize Montefiore Medical Center to release the above information to the Occupational Health Services (OHS) of all Montefiore OHS sites. **I understand this clinical data will be used for the sole purpose of compliance with applicable laws and regulations and all health clearance documentation (results, lab/titer reports, x-rays and written reports as required) will be available to Montefiore upon request.**

_____ _____

Signature of Volunteer Date

(Volunteer, please do not sign and date form until completed by health practitioner)